Britain’s health secretary just made a historic announcement.

In late October Andrew Lansley announced that the British government’s drug rationing body, the National Institute for Health and Clinical Excellence (NICE), would be stripped of its power to refuse new medicines based on cost.

Patients cheered. For years, in an effort to save the government money, NICE has denied Britons access to the latest drugs for cancer, Alzheimer’s and other ailments. This has resulted in countless fights with patient groups who recognize the value of putting care over cost.

But just as Britain is moving away from destructive cost-control policies in its health system, the U.S. seems to be embracing them. If American health policy-makers begin putting cost before quality, doctors might soon lose the freedom to treat patients without being obstructed by regulators. Countless patients could lose access to life-saving treatments.

In recent months there have been several troubling examples of the American government’s move toward a more cost-obsessed health care system.

Just look at the breast cancer drug Avastin. The Food and Drug Administration is considering rescinding approval of this drug for the treatment of advanced breast cancer.

For many women with advanced breast cancer Avastin is a lifesaver. When combined with chemotherapy in the drug’s critical phase III trial, Avastin increased progression-free survival for the average metastatic breast cancer patient by 5.5 months. However, averages don’t tell the real story; a substantial minority had significantly longer-lasting benefits.

A number of advocacy groups for patients with breast cancer have urged the FDA to maintain approval for this indication. But many have concluded—despite denials by those running the cancer drug section of the FDA—that the impending decision has been influenced by cost.

The FDA’s regulatory mandate does not include cost-benefit concerns. True, Avastin is certainly expensive—the drug can cost as much as $88,000 a year. If the FDA decides to rescind Avastin’s approval for breast cancer, both private and government insurers could stop paying for treatment, and likely thousands of women could lose access to the drug, as it would be unaffordable.

And that’s not Avastin’s only cost-control controversy.
The National Institutes of Health (NIH) is currently comparing two drugs for the treatment of age-related macular degeneration (AMD), a condition that causes vision deterioration among the elderly. Those two drugs: Avastin and Lucentis.

Even though Avastin isn't FDA approved for the treatment of AMD, it's widely used on an "off-label" basis for the disease. And for AMD, Avastin is pretty cheap--just $50 per treatment.

The other major treatment for AMD is Lucentis. Unlike Avastin, Lucentis is FDA-approved to treat AMD. The two drugs are related--and manufactured by the same company--but they're not the same. Lucentis, though, is much more expensive. It costs around $2,500 per treatment.

It's rather strange that the NIH is spending millions of dollars comparing these two treatments. One is FDA-approved to treat AMD; the other isn't. Doctors like having both options, as some patients respond better to one drug over the other. But if Avastin is shown to be at least comparable in effectiveness to the more costly Lucentis, AMD patients could lose access to the pricier drug. Faced with the choice of paying nearly $2,500 an injection for Lucentis, the bean-counters overseeing pharmacy formularies, including the federal programs, might simply require AMD patients to take Avastin instead.

Perhaps the most egregious example of government cost concerns getting in the way of treatment involves the cancer vaccine Provenge. In April of this year the FDA approved Provenge as a treatment for recurrence of prostate cancer. Although it's a one-time treatment, if carries a hefty price tag of $93,000.

The Centers for Medicare and Medicaid Services are currently considering whether or not Provenge will be covered under government health insurance programs. If they decide not to, it will be the first time in history the agency has refused to cover an FDA-approved cancer treatment.

Already the drug's path to approval has been mired in controversy. Indeed, Provenge was inexplicably stuck in the approval pipeline for years. This delay was tragic, given the fact that 30,000 American men die each year as a result of prostate cancer.

Add it all up, and it appears that the U.S. health system is on its way to British-style rationing. This shift in policy will bring with it the injustices and poor outcomes that have long been characteristic of Britain's National Health Service. All this has been insidiously infiltrating our health system even before the new health reform law takes effect, which will add another layer of cost-cutting based on rationing--although no one will use that term.

Controlling the cost of health care in the U.S. is indeed a vital issue. In 2008 alone the U.S. spent $2.3 trillion on health care. However, for America's system to maintain its status as the most effective in the world, new cost-control mechanisms can't compromise the health of patients or the freedom of physicians.

Forcing patients to make do with subpar treatments while preventing physicians from delivering the highest quality of care just shouldn't be an option.

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